SANFORD HEALTH

**Sanford Health Behavioral Health**

Name:_____Date of Birth: _____
Former name or maiden name:_____
Are you your own legal guardian? Yes___ No ___ If No, who is your legal guardian?_____
_____

Address:_____
City:_____ County: _____State:_____ Zip:_____
Phone number: Cell: _____ Home: _____

Emergency contact name:_____Phone: _____
Relationship to emergency contact person:_____

Are you currently receiving behavioral health services? Yes ___ No ___
If yes, where:_____

Is there anything you would like your treatment team to know regarding your needs (i.e.: court ordered, substance use related, interest in therapy or medications)?_____
_____
_____

**Consent for Treatment and use of PHI**: I acknowledge that I have consented to receive mental health and related services from staff of Sanford Health Behavioral Health which will be described in full in the treatment planning process. I understand that I must consent to receive services or I will not be served.

Patient Signature: _____Date _____

Guardian Signature: _____Date _____

Patient MRN:_____